

South Carolina Department of Health and Human Services
Application for
Gap Assistance Pharmacy Program for Seniors (GAPS)

Medicare provides prescription drug coverage for people eligible for Medicare. GAPS works with Medicare's prescription drug coverage this way:

Most people, who join a Medicare Prescription Drug Plan, after paying a monthly premium, will be responsible for 100% of their drug costs between \$2,830 and \$6,440. This gap in Medicare drug coverage that many people will face is referred to as the "doughnut hole." GAPS will provide state pharmacy assistance to "fill the gap" for seniors' Medicare prescription drug coverage when their drug costs reach the "doughnut hole". The GAPS program will pay 40% of your drug costs while you are experiencing the coverage gap.

Before you apply for GAPS, you will need to:

Check to see if you qualify for *Extra Help* through the Federal government with your prescription drug costs. The *Extra Help* program is for those with limited income and resources. If you qualify, *Extra Help* will benefit you more than GAPS. If you have not already checked to see if you qualify for *Extra Help*, please do so. Online applications are available at www.socialsecurity.gov or call (toll-free) 1-800-772-1213. (Note: You do not need GAPS if you qualify for *Extra Help*.)

If you qualify for GAPS, you will need to:

Join a Medicare Prescription Drug Plan (PDP). Medicare prescription drug coverage does not begin until you have joined a drug plan. To benefit from GAPS, you must select a PDP that is participating in GAPS. Not all PDPs participate in GAPS. Listed below are the participating providers and the Prescription Drug Plans that are participating in GAPS. Also listed for your convenience are their toll-free telephone numbers.

Medicare Part D Drug Plans	Plan	Phone Number
United Healthcare (S5820)	AARP MedicareRx Preferred (008)	888-867-5564
EnvisionRx Plus (S7694)	Silver Plan (009)	866-250-2005
Fox Insurance Company (S5557)	Value Plan (038)	888-369-7979
Medicare Part C HEALTH Plans	Plan	Phone Number
Care Improvement Plus (R9896)	Gold Rx (002)	866-766-8698
Care Improvement Plus (R9896)	Platinum Rx (003)	866-766-8698
Care Improvement Plus (R9896)	Silver Rx (001)	866-766-8698
Care Improvement Plus (R9896)	Gold Rx Advantage (004)	866-766-8698
Care Improvement Plus (R9896)	Platinum Rx Advantage (007)	866-766-8698

Note: GAPS is not a Medicaid program; however, it is administered by the South Carolina Department of Health and Human Services. Please contact your local Medicaid office if you have never applied for Medicaid benefits and think you may qualify. If you do not know where to go, visit our agency's Web site at www.scdhhs.gov or call (toll-free) 1-888-549-0820. Medicaid coverage will benefit you more than GAPS.

The following information is needed to process your **APPLICATION FOR GAPS**.
 This application will be processed based on the information you provide
 We will compare this information to other government agency
 computer systems for verification.
 The results of that verification could affect your eligibility for GAPS.

Application Type: <i>(Please check one.)</i>					<input type="radio"/> Individual <i>(Single, Separated, Divorced, or Widowed)</i> <input type="radio"/> Joint <i>(Married – you and your spouse)</i>				
YOUR INFORMATION (APPLICANT)									
First Name:				MI:		Last Name:			
Social Security Number:			Medicare Number:		Date of Birth:		<input type="radio"/> Male <input type="radio"/> Female		
Race: <div> <input type="radio"/> White <input type="radio"/> Mexican <input type="radio"/> Puerto Rican <input type="radio"/> Asian American/Oriental <input type="radio"/> African American/Black <input type="radio"/> Native American/ American Indian <input type="radio"/> Cuban <input type="radio"/> Other/Unknown <input type="radio"/> Hispanic </div>									
IF MARRIED, YOUR SPOUSE'S INFORMATION IS REQUIRED									
First Name:				MI:		Last Name:			
Social Security Number:			Medicare Number:		Date of Birth:		<input type="radio"/> Male <input type="radio"/> Female		
Race: <div> <input type="radio"/> White <input type="radio"/> Mexican <input type="radio"/> Puerto Rican <input type="radio"/> Asian American/Oriental <input type="radio"/> African American/Black <input type="radio"/> Native American/ American Indian <input type="radio"/> Cuban <input type="radio"/> Other/Unknown <input type="radio"/> Hispanic </div>									
YOUR HOME ADDRESS AND TELEPHONE									
Address: <i>(Include Apartment Number, if applicable.)</i>									
City:		State:		Zip Code:		County:		Telephone Number: ()	
YOUR MAILING ADDRESS <i>(Fill out this section only if your mailing address is different from your home address.)</i>									
Address: <i>(Include Apartment Number, if applicable.)</i>									
City:				State:			Zip Code:		

HOUSEHOLD INCOME INFORMATION

Income Type	Yourself		Spouse (If Married)	
	How Much?	How often received	How Much?	How often received
Veterans Benefits				
VA Aid and Attendance				
Social Security Payments				
Retirement Pension				
Railroad				
Unemployment Benefits				
Money from Trusts, Dividends, Interest, etc.				
Income from Rental Property				
Alimony				
Child Support				
Other <i>(Please explain.)</i>				

Your Income from Employment	Spouse's Income from Employment <i>(if living in the home)</i>
Employer Name & Phone Number: Amount you earn each month before taxes: \$ _____	Employer Name & Phone Number: Amount you earn each month before taxes: \$ _____

Number of family members in your household: _____ <i>(Your household includes yourself, your spouse and any family member you support.)</i>

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| <ul style="list-style-type: none"> Be sure to read the Rights and Responsibilities on Page 4. At least one of the following signatures is required. <i>This application is not valid without a signature.</i> |
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Applicant's Signature:	Date:	Spouse's Signature:	Date:
Authorized Representative's (AR) Signature: Print Name: Date:		Address & Phone Number of AR: () Relationship:	

Mail this completed and signed application form to:

SC Department of Health and Human Services
Division of Central Eligibility Processing
Post Office Box 100101
Columbia, South Carolina 29202-3101

Or fax to: (803) 255-8223

For DHHS Use Only

A. Household Size	
B. 200% of Federal Poverty Level for Household Size	\$ _____
C. Gross Monthly Household Income	\$ _____

Note: If the amount in C exceeds the amount in B, the individual is NOT eligible for GAPS.

RIGHTS AND RESPONSIBILITIES

1. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of GAPS. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and I will be receiving a Notice of Privacy Practices.
 - a. I know that any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
 - b. I know that DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
 - c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
 - d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
2. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 1, above.
3. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
4. I know that I must report any and all changes in my income, living arrangements, members of the household, or other information that may affect my eligibility within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
5. I know that I may request a hearing if I believe an error has been made in processing my application.